PROTOCOL CODE: ULYEPCOR Cycle 2+

A BC Cancer "Compassionate Access Program" request form must be completed and approved prior to treatment.

DOCTOR'S ORDERS

Ht_____cm Wt_____kg BSA_____m^2

REMINDER: Please ensure drug allergies and previous bleomycin are documented on the Allergy & Alert Form

DATE: **To be given:** **Cycle #:**

Date of Previous Cycle:

☐ Delay treatment _____ week(s)
☐ **CBC & Diff** day of treatment

May proceed with doses as written if within 48 hours **ANC greater than or equal to 0.5 x 10^9/L, platelets greater than or equal to 50 x 10^9/L**.

Proceed with treatment based on blood work from _____

- Physician to ensure antimicrobial prophylaxis

PREMEDICATIONS: Patient to take own supply. RN/Pharmacist to confirm _____.

☐ **prochlorperazine 10 mg** PO or ☐ **metoclopramide 10 mg** PO prior to each dose of epcoritamab

If required (if Grade 2 or 3 CRS with prior dose)
☐ **dexamethasone 16 mg** ☐ PO or ☐ IV (select one) 30 to 60 minutes prior to epcoritamab

If ordered, ensure patient continues to take dexamethasone for 3 consecutive days after epcoritamab dose

☐ **Other:**

****Have Hypersensitivity Reaction Tray & Protocol Available****

TREATMENT:

☐ **CYCLE #_____ (Cycle 2 and 3):**

epcoritamab 48 mg subcutaneous injection on **Days 1, 8, 15, and 22**

☐ **CYCLE #_____** (**Cycle 4 to 9):**

epcoritamab 48 mg subcutaneous injection on **Days 1 and 15**

☐ **CYCLE #_____** (**Cycle 10 onwards):**

epcoritamab 48 mg subcutaneous injection on **Day 1**

DOCTOR'S SIGNATURE:	**SIGNATURE:** **UC:**

DATE:	
RETURN APPOINTMENT ORDERS	
☐ Return in **four** weeks for Doctor and Cycle _____. Book treatment on Days 1, 8, 15 and 22. ☐ Return in **four** weeks for Doctor and Cycle _____. Book treatment on Days 1 and 15. ☐ Return in **four** weeks for Doctor and Cycle _____. Book treatment on Days 1 only.	
Prior to each treatment: **CBC & Diff** If clinically indicated: ☐ **creatinine** ☐ **sodium, potassium** ☐ **total bilirubin** ☐ **alkaline phosphatase** ☐ **LDH** ☐ **calcium** ☐ **ALT** ☐ **phosphate** ☐ **magnesium** ☐ **uric acid** ☐ **albumin** ☐ **random glucose** ☐ **immunoglobulin panel (IgA, IgG, IgM)** ☐ **HBV viral load** every 3 months ☐ **Consults:** ☐ **See general orders sheet for additional requests**	
DOCTOR'S SIGNATURE:	**SIGNATURE:** **UC:**